STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155200	A. BUILDING 00 B. WING	04/20/2012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: April 16, 17, 18, 19, 20, 2012 Facility number: 000107 Provider number: 155200 AIM number: 100290330 Survey team: Delinda Easterly RN TC Betty Retherford RN Ginger McNamee RN Karen Lewis RN Census bed type: SNF/NF: 56 Total: 56 Census payor type: Medicare: 9 Medicaid: 40 Other: 7 Total: 56 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 4/26/12 by Suzanne Williams, RN	F0000	Submission of this Plan of Correction does not constitutes an admission or agreement on our part with the deficiencies cited on the survey report.Please accept this Plan of Correction as our Credible Allegation of Compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure resident bathrooms were well maintained and in good repair for 11 of 35 resident bathrooms observed. (Room numbers 101, 103, 104, 106, 108, 109, 110,111, 112, 205 and 207) This had the potential to affect 22 residents residing in those rooms of 56 residents. Findings include: During the environmental tour with the Maintenance Director and the Housekeeping Supervisor on 4/19/12 at 1:30 p.m., the following concerns were identified: A. The bathroom in room 101 had sections of wallpaper that was loose and peeling away from the wall. The bathroom had 3 sections of floor tiles that were stained and discolored. The bathroom wall had 3 areas of dried white patching material on the wall. B. The bathroom in room 103 had sections of wallpaper that was loose and peeling away from the wall. The	F0253	F 253 Housekeeping and Maintenance Services What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · Rooms identified in the survey have been repaired including the walls and wallpaper, the floor tiles have been cleaned and the grout repaired, the doors and door frames were repaired and painted as needed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · All residents have the potential to be affected by this deficient practice. · All Department Managers have been assigned a section of resident rooms to monitor on a weekly basis. Findings from these room rounds will be documented on the Customer Care Room Rounds checklist. Items identified on the form as needing correction or repair will be forwarded to the Department Manager and the Executive Director for follow-up. · The Executive Director will monitor that the corrections have been made or if delayed an explanation will be given to the resident and/or responsible party.	05/20/2012

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	bathroom floor had 5 tiles around the base of the stool that had approximately a 1/4 inch gap between the tiles. The gap in the tiles exposed bare wood flooring. C. The bathroom in room 104 had 3 square sections of floor tiles which were stained and discolored. The bathroom metal door frames were gouged and had sections of paint missing from the frames. D. The metal door frames in bathroom 106 were gouged and had sections of paint missing from the frames. E. The bathroom in room 108 had 3 floor tile squares which were stained and discolored. F. The bathroom door to room 109 had several black scuff marks on the back of the door. The bathroom metal door frames were gouged and had sections of paint missing from the frames. G. The wooden entrance door to the bathroom in room 110 had 4 small holes in the door. The wooden door had sections where the door was scratched and marred.		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · All Department Managers have been assigned a section of resident rooms to monitor on a weekly basis. Findings from these room rounds will be documented on the Customer Care Room Rounds checklist. Items identified on the form as needing correction or repair will be forwarded to the Department Manager and the Executive Director for follow-up. · The Executive Director will monitor that the corrections have been made or if delayed an explanation will be given to the resident and/or responsible party. · The Executive Director inserviced the Department Managers on the Customer Care Room Rounds program and checklist. This checklist will be used to identify any resident care, and environmental or maintenance issues in the resident rooms and bathrooms. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place: · Executive Director/Designee will be responsible for monitoring the checklists on a weekly basis for 4 weeks, monthly for 3 months and quarterly thereafter. · Corrections identified on the Customer Care Room Rounds	

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	H. The bathroom in room 111 had sections of white dried patching material over several areas of the bathroom wall. 4 small holes were observed in the drywall in the bathroom wall near the sink. The caulk around the bathroom sink was cracked dry and sections of the caulk was missing. I. The bathroom in room 112 had sections of wallpaper that was peeling away from the wall. J. The metal bathroom door frame in room 205 was gouged and had paint missing from the frame. K. The bathroom in room 207 had 3 sections of floor tiles which were stained and or discolored. During an interview with the Maintenance Director at the time of the above observations, he indicated he was aware of all the concerns noted above. He further indicated he had a list of "on-going" concerns and would correct them as soon as he could. 3.1-19(f)		checklist tool will be discussed at the monthly CQI Meeting and the plan adjusted accordingly. By what date the systemic changes will be completed: · Systemic changes will be completed by 05/20/12.	

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A.) Based on observation, record review, and interview, the facility failed to ensure a resident residing on a secured unit was not moved to a non secured unit for an overnight visit without an assessment for safety and interventions in place to prevent elopement, for 1 of 1 resident reviewed for elopement of 18 residents residing on the secured unit. (Resident #38) B.) Based on observation, record review, and interview, the facility failed to ensure each resident had a functioning call light in place to summon staff for assistance to prevent possible falls, for 2 of 40 residents observed for a functional call light system. (Resident #58 and #60) Findings include: A1.) The clinical record for Resident #38 was reviewed on 4/17/12 at 3:00 p.m.	F0323	F 323 Free of Accident Hazards/Supervision/Devices What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · A1) All residents residing in the locked unit were reassessed for wandering. Those residents found to be at risk for wandering were given a Wander Guard alarm. Resident #38 was given an alarm. · B1) A new call light system will be installed on the locked unit by 05/20/12. The new call light system will be installed in all resident rooms including Room 210 where Residents 58 and 60 reside, the bathrooms and shower room. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · All residents have the potential to be affected by the deficient practice. · A1) All residents residing in the locked unit were reassessed for wandering. Those residents found to be at risk for wandering were given a Wander Guard alarm. Resident #38 was given an alarm. · B1) All resident	05/20/2012

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	Diagnoses for Resident #38 included, but were not limited to, debility, abnormal gait, multiple falls, unspecified mental retardation, disturbance conduct, depression, Parkinson's disease, Alzheimer's dementia, and anxiety. The clinical record indicated Resident #38 had resided on an alarmed secure unit since his readmission to the facility on 10/26/11 following a hospitalization for behavioral issues. The resident had previously resided on a non secured unit with his wife prior to hospitalization for aggressive behaviors towards his wife on 10/13/11. His previous bed in his wife's room remained unused. During an observation on 4/17/12 at 11:00 a.m., Resident #38 was observed to be ambulating in hall on the secured unit with his walker without assistance from the staff. A "Continuum of Care Plan" from the hospital behavioral unit, dated 10/26/11, indicated "Patient needs a safe, secure and highly supervised environment to insure the safety of the patient and others." A health care plan problem, dated 2/24/12, indicated Resident #38 had a		rooms including Room 210, the bathrooms and shower rooms and common areas in the facility have been checked for functioning call lights. Any call lights not working properly have been repaired or replaced. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · All staff was inserviced by the Executive Director on 05/08/12 on the call light system, the procedure for when a call light is not working properly, proper documentation, and the tools used to monitor the deficiency. · A1) DNS/ADNS inserviced the licensed nurses 05/10/12 on the Wander Guard system, testing the alarms on each shift, documenting in the TAR's and the procedure is an alarm is not working properly. · Resident alarms will be checked each shift by the charge nurse to ensure they are operating correctly. Monitoring of the alarms will be documented in Treatment Administration Records [TAR]. Any alarms found not working properly will be replaced with a new unit that has been tested by the charge nurse. · B1) DNS/ADNS inserviced the licensed nurses and CNA's on the call light system, ensuring they are in place and operational, documentation and the procedure to follow if one is not working properly. · All call lights in the	

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	need for placement on the secured unit due to a history of wandering and stating he was going to "walk out of here when you are not looking." The health care plan indicated the resident would reside on the secured unit and staff would verify the resident's location frequently. A nursing note entry, dated 2/9/12 at 7 p.m., indicated "Res [resident] down in room [number of wife's room] skilled hall to spend the night with wife." This hall was not part of the secured unit. The clinical record lacked any assessment of the resident or other interventions put in place to maintain his safety related to being off of the secured unit overnight. During an interview with the Administrator, Social Service Director, and Director of Nursing on 4/18/12 at 3:55 p.m., additional information was requested related to the supervision, safety and security of the resident when he stayed overnight with his wife on a non secured unit. During an interview with the Administrator on 4/19/12 at 8:25 a.m., she indicated she had talked to some of the nursing staff who had worked		facility will be checked on a weekly basis by the maintenance man and documented on his weekly Preventative Maintenance checklist. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place: · A1) DNS/Designee will monitor the TAR's on a daily basis for 4 weeks, weekly for 4 weeks, and then monthly thereafter for a minimum of 6 months. Any discrepancies will be corrected and logged on the CQI Resident Wander Guard Monitoring tool. · Weekend Manager/Designee will ensure that the alarms are being tested on the weekends and report any concerns to the Executive Director. · B1) Executive Director/Designee will monitor the CQI Preventative Maintenance checklist for call lights weekly for 4 weeks, then monthly thereafter for a minimum of 6 months. Any discrepancies found on the checklist will be verified that the call light has been repaired and documented on the CQI Resident Call Light Monitoring tool by the Executive Director. · All items identified on the CQI Resident Wander Guard Monitoring tool and the CQI Resident Call Light Monitoring tool will be discussed at the monthly CQI Meeting and the plan adjusted accordingly. The CQI Monitoring tools will be reviewed at the monthly CQI	

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	on the non secured unit on the night of 2/9/12. She indicated a CNA had told her she was aware of his being there, but did not remember any specifics related to the night in question. The Administrator indicated no assessment of his safety to be off of the secured unit had been done. She indicated no system had been put in place to ensure the resident did not attempt to elope the building or to ensure he was supervised while off of the alarmed secure unit. B1.) The clinical record for Resident #58 was reviewed on 4/19/12 at 8:45 a.m. Diagnoses for the resident included, but were not limited to, insomnia, encephalopathy, history of seizures, mass in the cerebellum hemisphere, and restless leg syndrome. The clinical record indicated the resident was able to ambulate independently. A "Fall Risk Assessment", dated 3/1/12, indicated Resident #58 was at risk for falls due to a seizure disorder, history of falls, and narcotic, antipsychotic, and hypnotic medication use. A health care plan problem, dated 3/5/12, indicated Resident #58 was at		meetings for a minimum of six months. By what date the systemic changes will be completed: · Systemic changes will be completed by 05/20/12.	

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	risk for falls due to a history of falls, history of seizures, medication use, and multiple diagnoses. One of the approaches for this problem was for the resident to have a "call light in reach." During an interview on 4/16/12 at 11:00 a.m., Resident #58 indicated she did not have a call light in her room. She indicated she had not had a call light since she was admitted in July 2011. She indicated she did not use the call light and would get up and come out into the hall if she needed something. She indicated she had never been given a bell or any other device to use to summon the staff if needed. During an observation on 4/16/12 at 11:30 a.m., there was no call light system present in the resident's room. The location on the wall for the call light system had a coverplate over the connection area. The call light in the bathroom was also noted to be not working. During an interview on 4/16/12 at 11:35 a.m., CNA #6 indicated Resident #58's room used to be used as an activity room, and it did not have a call light system in place.			

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	During an interview with the Administrator and Maintenance Supervisor on 4/16/12 at 11:40 a.m., additional information was requested related to there being not call light in Resident #58's room. During an observation of Resident #58's room with the Administrator and Maintenance Supervisor on 4/16/12 at 11:40 a.m., they indicated there was not a call light system in the resident's room and the bathroom call light was also not working. The administrator indicated Resident #58 should have a call light in the room and she did not know how this problem had been missed. She indicated steps would be taken to correct this problem and both residents in the room would be given bells to use until the call light was replaced. B2.) The clinical record for Resident #60 was reviewed on 4/19/12 at 9:30 a.m. The clinical record indicated Resident #60 had moved into her current room on 3/2/12. The clinical record indicated the resident was able to ambulate independently. Diagnoses for the resident included,			

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	but were not limited to, dementia, depression, history of falls, syncope, glaucoma, and hypertension. A "Fall Risk Assessment", dated 2/8/12, indicated Resident #60 was at risk for falls due to a history of falls, unsteady gait at times, confusion at times, and use of assuasive devises. A health care plan problem, dated 2/17/12, indicated Resident #60 was at risk for falls due to a history of falls, glaucoma, medication use, and syncope. One of the approaches for this problem was for the resident to have "personal items in reach including call light." During an interview on 4/16/12 at 11:20 a.m., Resident #60 indicated she did not have a call light in her room. She indicated she would "yell" if she needed something. She indicated she had never been given a bell or any other device to use to summon the staff if needed. During an observation on 4/16/12 at 11:30 a.m., there was no call light system present in the resident's room. The location on the wall for the call light system had a coverplate over the connection area. The call light in the bathroom was also noted to be not			

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	working. During an interview on 4/16/12 at 11:35 a.m., CNA #6 indicated Resident #60's room used to be used as a activity room and it did not have a call light system in place. During an interview with the Administrator and Maintenance Supervisor on 4/16/12 at 11:40 a.m., additional information was requested related to there being not call light in Resident #60's room. During an observation of Resident #60's room with the Administrator and Maintenance Supervisor on 4/16/12 at 11:40 a.m., they indicated there was not a call light system in the residents room and the bathroom call light was also not working. The administrator indicated Resident #60 should have a call light in the room and she did not know how this problem had been missed. She indicated steps would be taken to correct this problem and both residents in the room would be given bells to use until the call light was replaced. B3.) A review of the current facility policy, dated 9/05, provided by the Director of Nursing on 4/20/12 at 8:45			

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	a.m., titled "Call Light Procedure" included, but was not limited to, the following: "Purpose: To allow resident to request assistance when needed. Equipment: 1. Functioning call light. Procedure: 1. Place call light within reach of resident at all times...." 3.1-45(a)(2)			

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F0327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on observation, record review, and interview, the facility failed to offer fluids of the resident's choice in between meals for 1 of 21 residents interviewed for being offered fluids between meals. [Resident #5] Findings include: Resident #5's clinical record was reviewed on 4/18/12 at 9:21 a.m. The resident's diagnoses included, but were not limited to, corneal dystrophy, debility, anxiety, depression, dementia, and personality disorder. The resident had a 2/29/12, Significant Change Minimum Data Set assessment. The assessment indicated the resident was cognitively intact. Resident #5 had an Interdisciplinary Care Plan Conference on 2/22/12. The resident had a Problem of at risk for altered nutrition/hydration due to possible medical causes and/or increased nutrient requirements. This problem had an approach to provide preferences.	F0327	F 327 Sufficient Fluid to Maintain Hydration What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · Resident #5 is provided with lemonade between meals. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · All alert and oriented residents have the potential to be affected. · All alert and oriented residents including Resident #5 will be interviewed regarding their preferences for in-between meal hydration using the Dietary Resident Interview form. · The CNA assignment sheets have been updated to include the residents' preferences for in-between meal hydration. · The plan of care for potentially affected residents including Resident #5 have been reviewed and updated as indicated. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · Dietary Manager/Designee will be responsible for interviewing residents and completing the Dietary Resident	05/20/2012

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UNIVERSITY NURSING CENTER	1564 S UNIVERSITY BLVD UPLAND, IN 46989

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	During an interview with the resident on 4/16/12 at 3:05 p.m., Resident #5 indicated she did not drink water and refused to have it kept in her room. She indicated she prefers lemonade and her daughter keeps lemonade stocked in her closet. She indicated she would like to have a glass of it between meals. She indicated she is not able to get it for herself. She indicated she doesn't ask the staff to give her some because they are always in a hurry. She indicated they don't offer her anything except the water she declines. During an interview on 4/16/12 at 3:00 p.m., with the Director of Nursing, she indicated she was not aware of the resident wanting lemonade during the day. She indicated she would inform the staff and put it on the CNA assignment sheets. During an interview on 4/18/12 at 2:55 p.m., with CNA #3, he indicated the resident did not drink any water. He indicated the resident drank her fluids on her tray at meals. He indicated the resident had lemonade in her closest and he would give it to her when she asked for it. He indicated he had never asked the		Interview form on admission, readmission, quarterly, annually, and with significant changes to obtain resident preference for in-between meal hydration. · DNS/Designee will educate the nursing staff on 05/10/12 on the residents' preferences for in-between meal hydration. · DNS/Designee will update CNA assignment sheets with residents' preferences for in-between meal hydration. · The Interdisciplinary Care Plan team will review and update the residents' care plans as needed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place: · DSN/Designee will be responsible for ensuring residents hydration preferences are being honored by using the Hydration Preference CQI tool. This CQI tool will be used to randomly monitor all three shifts weekly x 4 weeks, then monthly for a minimum of six months. · The Hydration Preference CQI Monitoring tool will be reviewed at the monthly CQI meeting and the plan will be adjusted as needed. By what date the systemic changes will be completed: · Systemic changes will be completed by 05/20/12.	

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	resident if she would like some lemonade. Revised 3/08, "Hydration Management Program" was provided by the Director of Nursing on 4/20/12 at 8:40 a.m. The purpose of the program was to ensure all residents receive appropriate interventions to support adequate hydration each day unless otherwise directed by a physician or indicated by advance directives. The program indicated the resident will be included in assessing, planning, and intervention of controlling or eliminating risk, including providing for resident preferences on the plan of care. 3.1-46(b)			

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F0356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, record review and interview, the facility failed to ensure the list of nursing staff on duty was posted and updated on a daily basis as required. This had the potential to effect 56 residents who	F0356	F 356 Posted Nurse Staffing Information What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · Nurse staffing information will be updated and	05/20/2012

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	resided in the facility. Findings include: During the initial tour of the facility on 4/16/12 at 8:50 a.m. the nursing staff on duty posting was observed on the wall outside of the therapy department. The posting was dated 4/13/12. During an interview with Nursing Staff #7, on 4/16/12 at 9:00 a.m., she indicated the list of nursing staff on duty was to be updated daily at the beginning of each shift. She further indicated the posted list of staff on duty in the facility was dated 4/13/12. She indicated the list of staff should have been updated. 3.1-17(a)		posted daily in a clear readable format in a prominent place readily accessible to residents and visitors.. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · All residents have the potential to be affected by this practice. Nurse staffing information will be posted daily by the night shift charge nurse in a clear and readable format in a prominent place readily accessible to residents and visitors. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · DNS/Designee have educated the night shift charge nurses on posting the nurse staffing information daily. · Weekend Manager will ensure the nurse staffing information is posted on the weekends and document on the Weekend Managers Report. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place: · Executive Director/Designee will be responsible for monitoring the daily posting of the nurse staffing information on the Posted Nurse Staffing CQI tool. · Results of the Posted Nurse Staffing CQI tool will be discussed monthly at the CQI meeting for three months	

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			and then quarterly there after. The plan adjusted as needed. By what date the systemic changes will be completed: Systemic changes will be completed by 05/20/12.	

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F0371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure all items on room trays were covered while being transported from the food cart to the resident rooms for 1 of 2 food carts observed. This had the potential to affect 33 of 33 residents who had meal trays delivered on a food cart. Findings include: 1.) During an observation on the 300 Hall on 4/16/12 at 11:55 a.m., two staff members were observed passing food trays on the unit to residents who were eating in their rooms. The dietary cart was parked in the television lounge. The staff took the trays from the cart in the television lounge and carried them down the hallway to the resident rooms. Three of 3 trays observed had open, uncovered food items on them. Each tray had a bowl of coleslaw and peaches which were uncovered. Each tray also had	F0371	F 371 Food Procure, Store/Prepare/Serve - Sanitary What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · Dietary Manager inserviced the dietary staff on 05/08/12 on the proper procedure of distributing and serving food trays under sanitary conditions. · All food and beverages will be properly covered while being transported from the food cart to the resident rooms. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · All residents have the potential to be affected by the deficient practice. · Dietary Manager inserviced the dietary staff on 05/08/12 on the proper procedure of distributing and serving food trays under sanitary conditions. · The Executive Director inserviced all staff on 05/08/12 on the policy that all food being transported to the residents' room and the Auguste's Cottage Dining Room must be properly covered. · All food and beverages will be	05/20/2012

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	uncovered drinks. During an interview with kitchen cook #1 on 4/20/12 at 10:15 a.m., she indicated that 12 hall trays are served for breakfast, 10 hall trays are served for lunch, and 11 hall trays are served for supper.		properly covered while being transported from the food cart to the resident rooms. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · Dietary Manager inserviced the dietary staff on 05/08/12 on the proper procedure of distributing and serving food trays under sanitary conditions. · All food and beverages will be properly covered while being transported from the food cart to the resident rooms. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place: · Dietary Manager/Designee will monitor the trays before they leave the kitchen. Trays will be monitored at each meal to ensure food and beverages are properly covered at each including weekends for 4 weeks then monthly for a minimum of 6 months. Monitoring will be documented on the CQI Dietary Tray Monitoring tool. · The CQI Dietary Tray Monitoring tool will be reviewed at the monthly CQI Meeting and the plan will be adjusted accordingly. This CQI Monitoring tool will be reviewed at the CQI Meeting for a minimum of 6 months. By what date the systemic changes will be completed: · Systemic changes will be completed by 05/20/12.	

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	2.) During an observation on 4/18/12 at 7:50 a.m. The hall trays were being passed on the 100 hall. The milk glasses were not covered. 3.1-21(i)(3)	F0371	F 371 Food Procure, Store/Prepare/Serve - Sanitary What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · Dietary Manager inserviced the dietary staff on 05/08/12 on the proper procedure of distributing and serving food trays under sanitary conditions. · All food and beverages will be properly covered while being transported from the food cart to the resident rooms. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · All residents have the potential to be affected by the deficient practice. · Dietary Manager inserviced the dietary staff on 05/08/12 on the proper procedure of distributing and serving food trays under sanitary conditions. · The Executive Director inserviced all staff on 05/08/12 on the policy that all food being transported to the residents' room and the Auguste's Cottage Dining Room must be properly covered. · All food and beverages will be properly covered while being transported from the food cart to the resident rooms. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · Dietary Manager inserviced the dietary staff on 05/08/12 on the	05/20/2012

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			proper procedure of distributing and serving food trays under sanitary conditions. · All food and beverages will be properly covered while being transported from the food cart to the resident rooms. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place: · Dietary Manager/Designee will monitor the trays before they leave the kitchen. Trays will be monitored at each meal to ensure food and beverages are properly covered at each including weekends for 4 weeks then monthly for a minimum of 6 months. Monitoring will be documented on the CQI Dietary Tray Monitoring tool. · The CQI Dietary Tray Monitoring tool will be reviewed at the monthly CQI Meeting and the plan will be adjusted accordingly. This CQI Monitoring tool will be reviewed at the CQI Meeting for a minimum of 6 months. By what date the systemic changes will be completed: · Systemic changes will be completed by 05/20/12.	

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F0428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.			
	Based on interview and record review, the facility failed to ensure the Consultant Pharmacist reviewed medication orders to ensure directions were clear and to ensure the dosages did not exceed the maximum daily dose for 4 of 10 residents reviewed for unnecessary medications. [Resident #'s 5, 39, 55, 12] Findings include: 1.) Resident #5's clinical record was reviewed on 4/18/12 at 9:21 a.m. The resident's diagnoses included, but were not limited to, constipation, corneal dystrophy, debility, anxiety, depression, dementia, and personality disorder. The resident had a current order for docusate sodium [a stool softener] 100 mg capsule take one capsule by mouth three times daily once daily. This order was initiated on 12/31/11.	F0428	F 428 Drug Regimen Review, Report Irregular, Act on: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · Res. # 5, 39, 55, 12 medications have been reviewed and clarified with physician to ensure directions and indications are clear and dosages do not exceed maximum daily dosage. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · All residents with physicians orders for medications have the potential to be affected. · Physician orders will be reviewed daily by the DNS/Designee to ensure physician orders directions and indications are clear and maximum daily dosage is not exceeded. · DNS/ADNS inserviced the licensed nurses on 05/10/12 on how to properly write and transcribe physicians orders and the licensed nurses will be educated on medications with	05/20/2012

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	The physician had reviewed the current orders on 3/2/12. During an interview with the Director of Nursing on 4/20/12 at 10:05 a.m., she indicated the order was clarified on 4/18/12, to read docusate sodium capsule take one capsule by mouth three times a day for constipation. She indicated the pharmacist had reviewed the resident's physician's orders on 4/17/12 and had made no recommendations related to the docusate sodium order. 2.) Resident #39's clinical record was reviewed on 4/18/12 at 9:15 a.m. The resident's diagnoses included, but were not limited to, chronic kidney disease and congestive heart failure. The resident's current physician's orders were signed by the physician on 4/11/12. The physician's orders included an as needed order initiated on 2/23/12, for albuterol [a medication given to aid respiration] 0.083% 2.5/3ml vial: use one vial per nebulizer three times daily with ipratropium br [a medication given to aid respiration] 0.02% use one vial three times daily with albuterol per nebulizer. The order lacked an indication of when the medication was to be given.		maximum daily dosage. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · Physician orders will be reviewed daily by the DNS/Designee to ensure physician orders directions and indications are clear and maximum daily dosage is not exceeded. · DNS/ADNS inserviced the licensed nurses on 05/10/12 on how to properly write and transcribe physicians orders and the licensed nurses will be educated on medications with maximum daily dosage. · The Pharmacy Consultant will review the physicians order during her monthly visit to ensure the directions and indications are clear and the maximum daily dosage is not exceeded. · Physicians order recaps will be reviewed monthly by 2 licensed nurses to ensure directions and indications are clear and dosages do not exceed maximum daily dosage. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place: · DNS/Designee will complete the Pharmacy Service CQI tool weekly for 4 weeks, then monthly x 3 months, then quarterly thereafter. Results of the Pharmacy Service CQI tool will be discussed monthly at the CQI meeting and the plan will be adjusted accordingly. By what	

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	During an interview with the Director of Nursing on 4/18/12 at 3:45 p.m., she indicated the medication was for shortness of breath. During an interview with the Director of Nursing on 4/20/12 at 10:05 a.m., she indicated the Consultant Pharmacy had a 1/18/12, request to change the albuterol and ipratropium to prn [as needed]. During an interview with the Director of Nursing on 4/20/12 at 10:20 a.m., she indicated the Consultant Pharmacist had reviewed the resident's record on 3/19/12 and 4/17/12 and no other recommendations had been made. 3.) The clinical record for Resident #55 was reviewed on 4/18/12 at 1:03 p.m. Diagnoses for Resident #55 included, but were not limited to, hypertension, hyperlipidemia, and change in mental status. Current physician's orders for Resident #12 included, but were not limited to, the following orders: a. Nitrostat (a medication given for angina discomfort) 0.4 milligrams		date the systemic changes will be completed: · Systemic changes will be completed by 05/20/12.	

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	(mg) tablet sublingually as needed for chest pain (original order date 1/29/12) The clinical record lacked any information or directions from the physician related to how often this medication could be given. The clinical record indicated the pharmacist reviewed the physician's orders on 4/17/12, 3/19/12, and 2/16/12, and no recommendations were made to clarify the above noted incomplete physician's orders. During an interview with the Director of Nursing on 4/19/12 at 1:45 p.m., additional information was requested related to the lack of clarifications obtained for the medication noted above following pharmacy reviews on 4/17/12, 3/19/12, and 2/16/12. During an interview with the Director of Nursing on 4/20/12 at 10:30 a.m., she indicated there were no recommendations from the 4/17/12, 3/19/12, and 2/16/12 pharmacy reviews related to the above medication. 4.) The clinical record for Resident #12 was reviewed on 4/17/12 at 3:13 p.m.			

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	Diagnoses for Resident #12 included, but were not limited to, leg cramps, pain, and pain associated with pressure areas. Current physician's orders for Resident #12 included, but were not limited to, the following orders for pain: a. Tylenol (a pain medication) 325 milligrams (mg) tablet 2 tablets (650 mg) every 8 hours routinely daily (original order date 10/20/11) b. Vicodin (a pain medication that contains Tylenol) 5/325 mg 1 tablet twice a day (original order date 3/29/12) c. Tylenol (a pain medication) 325 mg tablet 2 tablets (650 mg) every 4 hours as needed for pain (original order date 12/1/11) d. Norco (a pain medication that contains Tylenol) 5/325 mg 1 tablet every 4 hours as needed for pain (original order date 3/15/12) e. Vicodin (a pain medication that contains Tylenol) 5/325 mg 1 tablet every 4 hours as needed for pain (original order date 3/15/12)			

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	The 2010 Nursing Drug Handbook indicated the maximum daily dose of Tylenol should not exceed 4000 mg in 24 hours. The March and April Narcotic sign out sheets for the as needed Vicodin order noted above indicated the Vicodin medication had been given 30 times on an as needed basis from 3/16/12 through 4/6/12. The clinical record indicated the pharmacist reviewed the physician's orders on 4/17/12 and no recommendations were made related to the resident exceeding maximum daily recommended dose of Tylenol. During an interview with the Director of Nursing on 4/20/12 at 9:54 a.m., additional information was requested related to the pharmacy consultant's report and lack of recommendations related to the Tylenol and the Vicodin orders following the 4/17/12 pharmacy review. During an interview with the Director of Nursing on 4/20/12 at 10:30 a.m., she indicated there were no recommendations from the 4/17/12 pharmacy review.			

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	5.) Review of the current facility policy, dated 7/11, titled "THE CLINICAL CONSULTANT PHARMACIST," provided by the Director of Nursing on 4/20/12, at 8:40 a.m., included, but was not limited to, the following: "Responsibilities include but are not limit to: Review of the drug regimen of each patient routinely. Any irregularities are reported to the Medical Director, Director of Nursing, and the Administrator...." 3.1-25(h)			

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F0463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation, record review, and interview, the facility failed to ensure each resident had a functioning call light in place in order to summon staff assistance for 2 of 40 residents observed for a functional call light system. (Resident #58 and #60) Findings include: 1.) The clinical record for Resident #58 was reviewed on 4/19/12 at 8:45 a.m. The clinical record indicated the resident was able to ambulate independently. During an interview on 4/16/12 at 11:00 a.m., Resident #58 indicated she did not have a call light in her room. She indicated she had not had a call light since she was admitted in July 2011. She indicated she did not use the call light and would get up and come out into the hall if she needed something. She indicated she had never been given a bell or any other device to use to summon	F0463	F 463 Resident Call System – Room/Toilet/Bath What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · A new call light system will be installed on the locked unit on 05/20/12. The new call light system includes all resident rooms, bathrooms and shower room. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · All residents have the potential to be affected by the deficient practice. · All resident rooms, bathrooms and shower rooms and common areas in the facility have been checked for functioning call lights. Any call lights not working properly have been repaired or replaced. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · All staff were inserviced by the Executive Director on 05/08/12 on the call light system, the procedure for when a call light is not working, proper documentation, and the tools used to monitor the	05/20/2012

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	the staff if needed. 2.) The clinical record for Resident #60 was reviewed on 4/19/12 at 9:30 a.m. The clinical record indicated Resident #60 had moved into her current room on 3/2/12. The clinical record indicated the resident was able to ambulate independently. During an interview on 4/16/12 at 11:20 a.m., Resident #60 indicated she did not have a call light in her room. She indicated she would "yell" if she needed something. She indicated she had never been given a bell or any other device to use to summon the staff if needed. 3.) During an observation on 4/16/12 at 11:30 a.m., there was no call light system present in the room shared by Resident #58 and #60. The location on the wall for the call light system had a coverplate over the connection area. The call light in the bathroom was also noted to be not working. During an interview on 4/16/12 at 11:35 a.m., CNA #6 indicated Resident #58 and #60's room used to be used as an activity room and it did not have a call light system in place.		deficiency. · DNS/ADNS inserviced the licensed nurses and CNA's on the call light system, ensuring they are in place and operational, documentation and the procedure to follow if one is not working properly. · All call lights in the facility will be checked on a weekly basis by the maintenance man and documented on his weekly Preventative Maintenance checklist. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place: · Executive Director/Designee will monitor the weekly Preventative Maintenance checklist for call lights. Any discrepancies found on the checklist will be verified that the call light has been repaired and documented on the CQI Resident Call Light Monitoring tool. · All items identified on the Resident Call Light Monitoring tool will be reviewed at the monthly CQI Meeting and the plan adjusted accordingly. By what date the systemic changes will be completed: · Systemic changes will be completed by 05/20/12.	

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During an interview with the Administrator and Maintenance Supervisor on 4/16/12 at 11:40 a.m., additional information was requested related to there being not call light system in place in the room shared by Resident #58 and #60.

During an observation of Resident #58 and #60's room with the Administrator and Maintenance Supervisor on 4/16/12 at 11:40 a.m., they indicated there was not a call light system in the resident's room and the bathroom call light was also not working. The administrator indicated Resident #58 and #60 should have a call light in their room and she did not know how this problem had been missed. She indicated steps would be taken to correct this problem and both residents in the room would be given bells to use until the call light was replaced.

4.) A review of the current facility policy, dated 9/05, provided by the Director of Nursing on 4/20/12 at 8:45 a.m., titled "Call Light Procedure" included, but was not limited to, the following:

"Purpose: To allow resident to

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	request assistance when needed. Equipment: 1. Functioning call light. Procedure: 1. Place call light within reach of resident at all times...." 3.1-19(u)(1) 3.1-19(u)(2)			

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F0465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on interview and observation, the facility failed to ensure drain covers were in place over 2 open drains in the dishroom, failed to ensure the kitchen floor had no missing tiles and failed to ensure there was no exposed gaps around a kitchen electrical outlet. This had the potential to affect 55 residents receiving meals from the kitchen of 56 residents. Findings include: During an observation of the kitchen on 4/19/12 at 11:15 a.m., with the Dietary Manager present. There was a floor tile missing in the right hand entrance to the dry storage room. There was an accumulation of dirt build up in the missing area. The left hand outer corner next to the kitchen janitor closest was missing a floor tile and base trim tile above the missing tile. The area had a build up of dirt collecting in it. Under the drying racks in the dishroom were two drain openings	F0465	F 465 Safe/Functional/Sanitary/Comfortable Environment What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · All items identified in the survey have been repaired including the missing drain covers, missing floor tiles, the accumulation dirt built up has been cleaned, trim tiles were replaced and the unused electrical outlet was removed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · All residents have the potential to be affected by this deficient practice. · All items identified in the survey have been repaired including the missing drain covers, missing floor tiles, the accumulation dirt built up has been cleaned, trim tiles were replaced and the unused electrical outlet was removed. · The Dietary Manager and staff will make observations daily of any necessary repairs. The needed repairs will be communicated to maintenance by completing a work order request. · The dietary department will be checked on a weekly basis by the	05/20/2012

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	with no covers over them. There was an electrical outlet in the stainless steel back splash of the three basin sink over the drying rack. The opening for the outlet was too large for the outlet box. There were gapping areas around the electric box. During an interview with the Dietary Manager at the time of the observation, she indicated she did not know what the plug-in was for and she had never been used. 3.1-19(f)		maintenance man and documented on his weekly Preventative Maintenance checklist. The checklist will be used to identify any environmental or maintenance issues in the dietary kitchen and storage areas that need repair. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · The Dietary Manager and staff will make observations daily of any necessary repairs. The needed repairs will be communicated to maintenance by completing a work order request · The dietary department will be checked on a weekly basis by the maintenance man and documented on his weekly Preventative Maintenance checklist. The checklist will be used to identify any environmental or maintenance issues in the dietary kitchen and storage areas that need repair. · The dietary floors will be deep cleaned on a monthly basis by the facility's floor care man. · Housekeeping/Laundry Supervisor will be responsible for ensuring the deep cleaning occurs on a monthly and document the cleaning on the monthly housekeeping schedule. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place:	

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			· Executive Director/Designee will be responsible for monitoring the Preventative Maintenance checklist on a weekly basis for 4 weeks, monthly for 3 months and quarterly thereafter. · Executive Director will monitor the housekeeping schedule to ensure the dietary floor was deep cleaned monthly as required. · Items identified on the Preventative Maintenance checklist tool or the will be discussed at the monthly CQI Meeting and the plan adjusted accordingly. By what date the systemic changes will be completed: · Systemic changes will be completed by 05/20/12.	

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F0514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to ensure medication orders were complete and dosage information was clear to ensure medications were given correctly and did not exceed the maximum daily dose, for 4 of 10 residents reviewed for unnecessary medications. [Resident #'s 5, 39, 55, 12] Findings include: 1.) Resident #5's clinical record was reviewed on 4/18/12 at 9:21 a.m. The resident's diagnoses included, but were not limited to, constipation, corneal dystrophy, debility, anxiety, depression, dementia, and personality disorder.	F0514	F 514 Resident Records – Complete/Accurate/Accessible What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · Res. # 5, 39, 55, 12 medications have been reviewed and clarified with physician to ensure directions and indications are clear and dosages do not exceed maximum daily dosage. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · All residents with physicians orders for medications have the potential to be affected. · Physician orders will be reviewed daily by the DNS/Designee to ensure physician orders directions and indications are clear and maximum daily dosage is not exceeded. · DNS/ADNS	05/20/2012

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	The resident had a current order for docusate sodium [a stool softener] 100 mg capsule take one capsule by mouth three times daily once daily. This order was initiated on 12/31/11. The physician had reviewed the current orders on 3/2/12. During an interview with the Director of Nursing on 4/20/12 at 10:05 a.m., she indicated the order was clarified on 4/18/12, to read docusate sodium capsule take one capsule by mouth three times a day for constipation. 2.) Resident #39's clinical record was reviewed on 4/18/12 at 9:15 a.m. The resident's diagnoses included, but were not limited to, chronic kidney disease and congestive heart failure. The resident's current physician's orders were signed by the physician on 4/11/12. The physician's orders included an as needed order initiated on 2/23/12, for albuterol [a medication given to aid respiration] 0.083% 2.5/3ml vial: use one vial per nebulizer three times daily with ipratropium br [a medication given to aid respiration] 0.02% use one vial three times daily with albuterol per nebulizer. The order lacked an indication of when the medication was to be given.		inserviced the licensed nurses on 05/10/12 on how to properly write and transcribe physicians orders and the licensed nurses will be educated on medications with maximum daily dosage. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · Physician orders will be reviewed daily by the DNS/Designee to ensure physician orders directions and indications are clear and maximum daily dosage is not exceeded. · DNS/ADNS inserviced the licensed nurses on 05/10/12 on how to properly write and transcribe physicians orders and the licensed nurses will be educated on medications with maximum daily dosage. · The Pharmacy Consultant will review the physicians order during her monthly visit to ensure the directions and indications are clear and the maximum daily dosage is not exceeded. · Physicians order recaps will be reviewed monthly by 2 licensed nurses to ensure directions and indications are clear and dosages do not exceed maximum daily dosage. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place: · DNS/Designee will complete the Pharmacy Service CQI tool weekly for 4 weeks, then monthly x 3 months, then	

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	During an interview with the Director of Nursing on 4/18/12 at 3:45 p.m., she indicated the medication was for shortness of breath. During an interview with the Director of Nursing on 4/20/12 at 10:20 a.m., she indicated the pharmacy recommendation on 1/18/12, was to change the albuterol and ipratropium from a routine order to an as needed order. 3.) The clinical record for Resident #55 was reviewed on 4/18/12 at 1:03 p.m. Diagnoses for Resident #55 included, but were not limited to, hypertension, hyperlipidemia, and change in mental status. Current physician's orders for Resident #12 included, but were not limited to, the following orders for pain: a. Nitrostat (a medication given for angina discomfort) 0.4 milligrams (mg) tablet sublingually as needed for chest pain (original order date 1/29/12) The order lacked any information related to how often the medication could be		quarterly thereafter. Results of the Pharmacy Service CQI tool will be discussed monthly at the CQI meeting and the plan will be adjusted accordingly. By what date the systemic changes will be completed: · Systemic changes will be completed by 05/20/12.	

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	given. During an interview with the Director of Nursing on 4/19/12 at 1:45 p.m., additional information was requested related to the order not being complete for the Nitrostat medication. During an interview with the Director of Nursing on 4/19/12 at 2:50 p.m., she indicated the order for the Nitrostat medication had not been clarified with the physician. 4.) The clinical record for Resident #12 was reviewed on 4/17/12 at 3:13 p.m. Diagnoses for Resident #12 included, but were not limited to, leg cramps, pain, and pain associated with pressure areas. Current physician's orders for Resident #12 included, but were not limited to, the following orders for pain: a. Tylenol (a pain medication) 325 milligrams (mg) tablet 2 tablets (650 mg) every 8 hours routinely daily (original order date 10/20/11) b. Vicodin (a pain medication that contains Tylenol) 5/325 mg 1 tablet			

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	twice a day (original order date 3/29/12) c. Tylenol (a pain medication) 325 mg tablet 2 tablets (650 mg) every 4 hours as needed for pain (original order date 12/1/11) d. Norco (a pain medication that contains Tylenol) 5/325 mg 1 tablet every 4 hours as needed for pain (original order date 3/15/12) e. Vicodin (a pain medication that contains Tylenol) 5/325 mg 1 tablet every 4 hours as needed for pain (original order date 3/15/12) The 2010 Nursing Drug Handbook indicated the maximum daily dose of Tylenol should not exceed 4000 mgs in 24 hours. The March and April Narcotic sign out sheets for the as needed Vicodin order noted above indicated the Vicodin medication had been given 30 times on an as needed basis from 3/16/12 through 4/6/12. During an interview with the Director of Nursing on 4/19/12 at 1:45 p.m., additional information was requested related to the Tylenol order not including the maximum daily dosage			

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	since the resident had multiple orders for medications containing Tylenol. During an interview with the Director of Nursing on 4/19/12 at 2:50 p.m., she indicated she had no additional information to provide related to the incomplete Tylenol order. 3.1-50(a)(1) 3.1-50(a)(2)			

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F0516 SS=B	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use.			
	Based on observation, record review, and interview, the facility failed to ensure resident clinical records were secured from possible fire damage for 18 of 18 residents who reside on the secured unit. Findings include: During an observation on the secured unit on 4/17/12 at 9:30 a.m., the fire alarm sounded in the facility. Multiple staff responded to the secured unit and indicated the alarm was not a drill and the alarm system identified the possible fire as being on the secured unit. The facility staff removed all residents and the Medication Administration Records to a lounge located on the	F0516	F 516 Release Resident Info, Safeguard Clinical Records What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · Residents' medical records will be secured from possible fire damage per facility policy. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · All residents have the potential to be affected by this deficient practice. · Residents' medical records will be secured from possible fire damage per facility policy. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · Executive Director inserviced the staff on 05/08/12 on the fire policy and procedure for securing	05/20/2012

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	155200	A. BUILDING 00 B. WING	04/20/2012

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	other side of the fire doors. The fire department responded to the fire alarm. The resident's clinical records were located behind the nursing station on a cart with wheels. The staff did not remove the resident clinical records off of the secured unit to the other side of the fire doors. During an interview with the Administrator on 4/17/12 at 10:00 a.m., additional information was requested regarding the clinical records not being taken from the unit when it was evacuated. During an interview with the Administrator on 4/17/12 at 10:20 a.m., she indicated the resident clinical records should have been moved off of the secured unit to the other side of the fire doors in accordance with facility policy. A review of the current, but undated, facility policy, provided by the Administrator on 4/17/12 at 10:20 a.m., titled "Procedure for Staff Response to Battery Powered Smoke Detectors" included, but was not limited to, the following: "...4. Remove charts and med		the residents' medical records during a fire drill or alarm. · Charge Nurse/s/Designee will be responsible for removing the medical records out of the fire zone during the fire drill or alarm. · The medical records will remain out of the fire zone area until the all clear has been issued and the residents have been returned to the area. · The removal of the residents' medical records will be documented on fire drill form. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place: · DNS/Designee will be responsible for monitoring the fire drill forms to ensure that the residents' records are removed during a fire drill or fire alarm. · DNS/Designee will be responsible for monitoring the fire drill forms on a monthly basis for 3 months and quarterly thereafter for six months. · Issues identified on the fire drill form will be discussed at the monthly CQI Meeting and the plan adjusted accordingly. By what date the systemic changes will be completed: · Systemic changes will be completed by 05/20/12.	

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	[medication] books past fire doors once all residents have been removed to safe areas...." 3.1-50(e)			

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F0520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on interview, the facility Quality Assessment and Assurance Committee failed to develop and implement appropriate plans of action to address the lack of call lights for 2 of 40 residents (Resident #58 and #60) observed for a functional call light system and environmental maintenance issues identified during the annual Recertification and State Licensure survey, in resident bathrooms, for 11 of 35 resident	F0520	. F 520 QAA Committee – Members. Meet Quarterly/Plan What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · The facility's QAA/CQI Committee met on 05/16/12 to address the survey plan of correction including the call lights and Wander Guard alarms and to implement plans to correct any concerns noted from the CQI monitoring tools. How other residents having the potential to	05/20/2012

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	bathrooms observed (Room numbers 101, 103, 104, 106, 108, 109, 110, 111, 112, 205 and 207), potentially affecting 22 residents residing in those rooms, of 56 residents in the facility. Findings include: During an interview on 4/20/12 at 8:25 a.m., the Administrator indicated the facility quality assurance program had not identified: The lack of a call light present in the room occupied by Resident #58 and #60, and environment concerns in the bathrooms of rooms 101, 103, 104, 106, 108, 109, 110,111, 112, 205 and 207, potentially affecting 22 residents residing in those rooms. The Administrator indicated a plan had not been put in place to address environmental issues prior to her first QA (quality assurance) meeting held on 4/11/12 after her placement as an Interim Administrator in the facility on 4/1/12. 3.1-52(b)(2)		be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · All residents have the potential to be affected by this deficient practice. · The facility's QAA/CQI Committee will meet on a monthly basis to monitor, evaluate, and provide follow-up action to continually improve and provide excellence in care and service. · CQI monitoring tools formulated by the survey will be reviewed and plans will be implemented to correct any concerns from the CQI monitoring tools. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · The facility's QAA/CQI Committee will meet on a monthly basis to monitor, evaluate, and provide follow-up action to continually improve and provide excellence in care and service. The process includes all departments and key facility practices. · CQI monitoring tools formulated by the survey will be reviewed and plans will be implemented to correct any concerns from the CQI monitoring tools. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place: · Monitoring tools formulated by the survey plan of correction will also be discussed at the monthly CQI meeting. for 3	

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			months and then quarterly thereafter for six months. The plans will be adjusted as needed to ensure all issues are reviewed and corrected. By what date the systemic changes will be completed: · Systemic changes will be completed by 05/20/12. .	